Guided self-help to reduce psychological distress: what's the potential for scaling up?

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In their cluster randomised controlled trial of guided self-help to reduce psychological distress in female Sudanese refugees in *The Lancet Global Health*,[1] Wietse A Tol and colleagues have taken global mental health to a new and hopeful place. The intervention of guided self-help was delivered in exacting conditions in a refugee settlement to women who had high exposure to trauma, and where mental health specialists are scarce. No psychiatric diagnosis was required to receive the intervention, and women did not need to disclose exposure to sensitive traumatic experiences. The only inclusion criterion was that women reported at least moderate levels of psychological distress. The premise of the intervention was that existing coping strategies could be helpfully and appropriately supported to alleviate symptoms of mental ill health.[2] The findings indicate that this was a successful approach, with women in the intervention group having reduced levels of distress, fewer symptoms of depression and post-traumatic stress, improvement in functioning, and improvement in overall wellbeing. In summary, guided self-help is a low-intensity psychosocial intervention that minimises risk of stigma, focuses on positive mental health, and is effective. The question now is how can this promising and potentially scalable intervention be transitioned to make real-world impact? We discuss four considerations for scale-up.

First, to consider how an intervention can be standardised while maintaining flexibility. Supportive psychosocial interventions in humanitarian settings, such as Psychological First Aid,[3] might seem to be based on common sense; however, in refugee and humanitarian settings, common sense does not always prevail. Sometimes, mental health is ignored altogether; at other times, well-intentioned responders might act in ways that undermine cultural coping or pathologise social suffering.[4] In the same way that Psychological First Aid offers early humanitarian responders a structured way to provide an appropriate response to overwhelming situations without doing harm, guided self-help holds the promise of facilitating the emergence of resilience in populations exposed to high levels of adversity. Standardising the approach, while allowing for cultural and contextual adaptation, is an essential step towards ensuring quality of care and reducing the risk of harms when scaling up. Cultural adaptation of interventions results in better outcomes,[5] but can be resource intensive. Whether this version of guided self-help can be easily adapted for other settings is yet to be seen; however, its success in this challenging context indicates that further adaptation for other humanitarian settings will be feasible.

Second, to be truly scalable and live up to its promise, guided self-help intervention should not rely on extensive external facilitation. In the version of guided self-help tested by Tol and colleagues, facilitators received a comparable amount of training and time investment to that given to service providers of more intensive psychological interventions.[6] The need for this level of support might be explained by the content of the sessions being more theoretically complex than a supportive intervention such as Psychological First Aid, as well as the need for group facilitation skills. However, even in its current form, a strength of this guided self-help intervention is that it will allow many more people experiencing psychological distress to receive a helpful intervention. Now that this trial has established no evident harms of guided self-help, future investigators can be bolder in reducing the extent of facilitation (and associated training and supervision of facilitators) to make the intervention even more scalable.

Third, the dilemma for all scale-up efforts, but especially for interventions involving non-specialists, is how to maintain the quality of services. In Tol and colleagues' study, the investigators report near-perfect fidelity. Although under trial conditions, it shows what can be achieved. How can quality be maintained in a real-world setting, especially if there were lower levels of facilitation? One approach to quality assurance could be to shift the onus more towards the service users. Observational scales have been validated in resource-poor settings that allow valid rating of the competence of service providers in core psychosocial skills, with a view to driving up quality of care.[7] Greater involvement of the beneficiaries themselves in assessing fidelity and adherence, and facilitator competencies, could embed quality control in a sustainable and more scalable way.

Fourth, it is necessary to consider the scope of the intervention. To allow for even greater reach, and based on the reported results, guided self-help could be reconceptualised as a secondary prevention intervention targeted at people with psychological distress. The implications of this reconceptualising as a preventive approach is that the intervention can be offered to all populations facing serious adversity, without the need to screen. The mechanisms of action of the intervention should be further investigated, particularly to understand how to achieve greater psychological flexibility, which might be a more enduring benefit of the intervention. Future trials should investigate whether emergence of mental health disorders is diminished by guided self-help. Lastly, although guided self-help was evaluated in a humanitarian setting, there is arguably as much need and potential for benefit in non-humanitarian settings, where social adversity is a fact of daily life—again increasing the potential of guided self-help to achieve real scale.

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